PUBLIC HEALTH SERVICE ACT

[As Amended Through P.L. 116–260, Enacted December 27, 2020]

[Currency: This publication is a compilation of the text of title XXVII of Chapter 373 of the 78th Congress. It was last amended by the public law listed in the As Amended Through note above and below at the bottom of each page of the pdf version and reflects current law through the date of the enactment of the public law listed at https://www.govinfo.gov/app/collection/comps/]

[Note: While this publication does not represent an official version of any Federal statute, substantial efforts have been made to ensure the accuracy of its contents. The official version of Federal law is found in the United States Statutes at Large and in the United States Code. The legal effect to be given to the Statutes at Large and the United States Code is established by statute (1 U.S.C. 112, 204).]

[References in brackets [] are to title 42, United States Code]

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—INDIVIDUAL AND GROUP MARKET REFORMS

Subpart I—General Reform

SEC. 2701. [300gg] FAIR HEALTH INSURANCE PREMIUMS.

(a)[1] PROHIBITING DISCRIMINATORY PREMIUM RATES.—

(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) RATING AREA.—

[1] There are no subsections following subsection (a) in section 2701.

(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

SEC. 2702. [300gg–1] GUARANTEED AVAILABILITY OF COVERAGE.

(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) ENROLLMENT.—

(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) SPECIAL RULES FOR NETWORK PLANS.—

(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals employees and dependents.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

SEC. 2703. [300gg–2] GUARANTEED RENEWABILITY OF COVERAGE.

(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such

coverage at the option of the plan sponsor or the individual, as applicable.

(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) FRAUD.—The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(4) TERMINATION OF COVERAGE.—The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).

(6) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

(A) the issuer provides notice to each plan sponsor or individual, as applicable, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor or individual, as applicable, provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage cur-

rently being offered by the issuer to a group health plan or individual health insurance coverage[2] in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

(i) the issuer provides notice to the applicable State authority and to each plan sponsor or individual, as applicable, (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more

[2] Section 1563(c)(9)(C)(i)(III)(bb) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148 provides for an amendment to insert "or individual health insurance coverage". Such amendment did not specify where to insert this new language, however, it was carried out by inserting such language after "group health plan" to reflect the probable intent of Congress.

associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

SEC. 2704. [300gg–3] PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) DEFINITIONS.—For purposes of this part—

(1) PREEXISTING CONDITION EXCLUSION.—

(A) IN GENERAL.—The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) ENROLLMENT DATE.—The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) LATE ENROLLEE.—The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) WAITING PERIOD.—The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

(1) CREDITABLE COVERAGE DEFINED.—For purposes of this title, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act.

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

(E) Chapter 55 of title 10, United States Code.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5, United States Code.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c)).

(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-ELIGIBLE INDIVIDUALS.—In the case of plan years beginning before January 1, 2014 [3]—

(i) TAA PRE-CERTIFICATION PERIOD RULE.—In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of the Internal Revenue Code of 1986 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) DEFINITIONS.—The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 2205(b)(4).

(3) METHOD OF CREDITING COVERAGE.—

(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

[3] The date specified in subparagraph (C) reflects the probable intent of Congress. Section 242(a)(4) of Public Law 112–40 provides for an amendment to section 2704(c)(2)(C) of the Public Health Service Act (as in effect for plan years beginning on or after January 1, 2014), by striking "February 13, 2011" and inserting "January 1, 2014".

The amendment made by Public Law 112–40 to section 2704(c)(2)(C), as transferred, redesignated, and amended by Public Law 111–148 (effective beginning on January 14, 2014), was carried after executing the amendment made by section 114(c) of Public Law 111–344.

(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group or individual health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) ISSUER NOTICE.—In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group group [4] market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) EXCEPTIONS.—

(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adop-

[4] So in law. See amendment made by section 1563(c)(1)(A)(ii)(II) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148.

tion or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) SPECIAL ENROLLMENT PERIODS.—

(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) FOR DEPENDENT BENEFICIARIES.—

(A) IN GENERAL.—If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI

of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) COORDINATION WITH MEDICAID AND CHIP.—

(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDI-

VIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) USE OF AFFILIATION PERIOD BY HMOS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

(1) IN GENERAL.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) AFFILIATION PERIOD.—

(A) DEFINED.—For purposes of this title, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) BEGINNING.—Such period shall begin on the enrollment date.

(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the require-

ments of this part for the State involved with respect to such issuer.

SEC. 2705. [300gg–4] PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) IN PREMIUM CONTRIBUTIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) NO GROUP-BASED DISCRIMINATION ON BASIS OF GENETIC INFORMATION.—

(A) IN GENERAL.—For purposes of this section, a group health plan, and health insurance issuer offering group or individual health insurance coverage, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d)

shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) GENETIC TESTING.—

(1) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) LIMITATION.—For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) RESEARCH EXCEPTION.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 2791).

(2) PROHIBITION ON COLLECTION OF GENETIC INFORMATION PRIOR TO ENROLLMENT.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) INCIDENTAL COLLECTION.—If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) APPLICATION TO ALL PLANS.—The provisions of subsections (a)(6), (b)(3), (c), and (d) and subsection (b)(1) and section 2704 with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 2735(a).

(f) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(j)[5] PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

(1) GENERAL PROVISIONS.—

(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a "wellness program") shall be a program offered by an employer that is

[5] So in law. There are no subsections (g)–(i).

designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related

to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically

inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

(3) REQUIREMENTS.—

(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not lead to cost shifting; and

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(m) REPORT.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

SEC. 2706. [300gg–5] NON-DISCRIMINATION IN HEALTH CARE.

(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance

issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

SEC. 2707. [300gg–6] COMPREHENSIVE HEALTH INSURANCE COVERAGE.

(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraph (1) of section 1302(c).

(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

SEC. 2708. [300gg–7] PROHIBITION ON EXCESSIVE WAITING PERIODS.

A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.

SEC. 2709. [300gg–8] COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.[6]

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

(2) ROUTINE PATIENT COSTS.—

(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage pro-

[6] So in law. There are two section 2709's. The first section 2709 (relating Disclosure of Information), was former section 2713, which was then redesignated as 2733 (by section 1001(3) of Public Law 111–148), then redesignated again to section 2709 and transfered to appear after section 2708 (by section 1563(c)(10)(C) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of such Public Law).

vided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

(i) the investigational item, device, or service, itself;

(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term "qualified individual" means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

(2) Either—

(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, de-

tection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Health Care Research and Quality.

(iv) The Centers for Medicare & Medicaid Services.

(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following if the conditions described in paragraph (2) are met:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require

a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.

SEC. 2709. [300gg–9] DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—In connection with the offering of any health insurance coverage to a small employer or an individual, a health insurance issuer—

(1) shall make a reasonable disclosure to such employer,,[7] or individual, as applicable, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

(2) upon request of such a employer, or individual, as applicable,,[7] or individual, as applicable, provide such information.

(b) INFORMATION DESCRIBED.—

(1) IN GENERAL.—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a employer, or individual, as applicable,,[7] information described in this subsection is information concerning—

(A) the provisions of such coverage concerning issuer's right to change premium rates and the factors that may affect changes in premium rates; and

(B) the benefits and premiums available under all health insurance coverage for which the employer, or individual, as applicable, is qualified.

(2) FORM OF INFORMATION.—Information under this subsection shall be provided to employers, or individuals, as applicable, in a manner determined to be understandable by the average employer, or individual, as applicable,,[7] and shall be sufficient to reasonably inform employers, or individuals, as applicable, of their rights and obligations under the health insurance coverage.

(3) EXCEPTION.—An issuer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

Subpart II—Improving Coverage[8]

SEC. 2711. [300gg–11] NO LIFETIME OR ANNUAL LIMITS.

(a) PROHIBITION.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted an-

[7] So in law.
[8] There is a subpart 2 (arabic 2) beginning with section 2722.

nual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term "restricted annual limit" for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.

SEC. 2712. [300gg–12] PROHIBITION ON RESCISSIONS.

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

SEC. 2713. [300gg–13] COVERAGE OF PREVENTIVE HEALTH SERVICES.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) INTERVAL.—

(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

SEC. 2714. [300gg–14] EXTENSION OF DEPENDENT COVERAGE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

(b) REGULATIONS.—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of "dependent" as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

SEC. 2715. [300gg–15] DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the "NAIC"), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost sharing for—

(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

(ii) other benefits, as identified by the Secretary;

(C) the exceptions, reductions, and limitations on coverage;

(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

(E) the renewability and continuation of coverage provisions;

(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

(G) a statement of whether the plan or coverage—

(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

(d) REQUIREMENT TO PROVIDE.—

(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

(A) an applicant at the time of application;

(B) an enrollee prior to the time of enrollment or re-enrollment, as applicable; and

(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR

(usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

SEC. 2715A. [300gg–15a] PROVISION OF ADDITIONAL INFORMATION.

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

SEC. 2716. [300gg–16] PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

(b) RULES AND DEFINITIONS.—For purposes of this section—

(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

(2) HIGHLY COMPENSATED INDIVIDUAL.—The term "highly compensated individual" has the meaning given such term by section 105(h)(5) of such Code.

SEC. 2717. [300gg–17] ENSURING THE QUALITY OF CARE.

(a) QUALITY REPORTING.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection

and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) REPORTING REQUIREMENTS.—

(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

(1) Smoking cessation.
(2) Weight management.
(3) Stress management.
(4) Physical fitness.
(5) Nutrition.
(6) Heart disease prevention.
(7) Healthy lifestyle support.
(8) Diabetes prevention.

(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

(1) WELLNESS AND PREVENTION PROGRAMS.—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

(A) the lawful ownership or possession of a firearm or ammunition;

(B) the lawful use of a firearm or ammunition; or

(C) the lawful storage of a firearm or ammunition.

(3) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use or storage of a firearm or ammunition.

(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use, possession, or storage of a firearm or ammunition.

(d) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

(e) STUDY AND REPORT.—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations

and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

SEC. 2718. [300gg–18] BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

(1) on reimbursement for clinical services provided to enrollees under such coverage;

(2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the applica-

tion of such 80 percent may destabilize the individual market in such State.

(B) REBATE AMOUNT.—

(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

SEC. 2719. [300gg–19] APPEALS PROCESS.

(a) INTERNAL CLAIMS APPEALS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

(A) have in effect an internal claims appeal process;

(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

SEC. 2719A. [300gg–19a] PATIENT PROTECTIONS.

(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network; [9]

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of

[9] Probably should read "; and".

the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this subsection:

(A) EMERGENCY MEDICAL CONDITION.—The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term "emergency services" means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term "to stabilize", with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) ACCESS TO PEDIATRIC CARE.—

(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) GENERAL RIGHTS.—

(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological

care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(e) APPLICATION.—The provisions of this section shall not apply with respect to a group health plan, health insurance issuers, or group or individual health insurance coverage with respect to plan years beginning on or on January 1, 2022.

SEC. 2725.[10] [300gg–25] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

[10] The placement of this section and succeeding sections 2726, 2727, and 2728 here, versus after section 2724, is ambiguous insofar as these sections at the time of their redesignation from sections 2704–2708 were not explicitly moved to follow section 2724, yet the failure to place them after section 2724 results in these sections not following ordinary sequential numbering.

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any health insurance issuer offering group or individual health insurance coverage, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group

health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group or individual health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed as superseding a State law described in paragraph (1).

SEC. 2726. [300gg–26] PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the

"applicable lifetime limit"), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by sub-

stituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

(A) IN GENERAL.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) DEFINITIONS.—In this paragraph:

(i) FINANCIAL REQUIREMENT.—The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) TREATMENT LIMITATION.—The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the

health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled "Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance".

(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, based on investigations of violations of such sections, including—

(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved

for approving mental health and substance use disorder benefits.

(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable; and

(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

(7) ADDITIONAL GUIDANCE.—

(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

(B) DISCLOSURE.—

(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining—

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

(8) COMPLIANCE REQUIREMENTS.—

(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as "NQTLs") on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after the date of enactment of the Consolidated Appropriations Act, 2021, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written

and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

(B) SECRETARY REQUEST PROCESS.—

(i) SUBMISSION UPON REQUEST.—The Secretary shall request that a group health plan or a health insurance issuer offering group or individual health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

(ii) ADDITIONAL INFORMATION.—In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

(iii) REQUIRED ACTION.—

(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the

Secretary that the plan or issuer is not in compliance; and

(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

(II) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section;

(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

(V) the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section

must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

(C) COMPLIANCE PROGRAM GUIDANCE DOCUMENT UPDATE PROCESS.—

(i) IN GENERAL.—The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

(ii) GUIDANCE AND REGULATIONS.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).

(b) CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall in-

clude employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) COST EXEMPTION.—

(A) IN GENERAL.—With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan)[11] seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) NOTIFICATION.—

(i) IN GENERAL.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan)[11] that, based upon a certification

[11] In section 1563 (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148, Congress may have intended to replace the parenthetical with a reference to both group and individual health insurance. The Congression intent is unclear.

described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) REQUIREMENT.—A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) CONFIDENTIALITY.—A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) DEFINITIONS.—For purposes of this section—

(1) AGGREGATE LIFETIME LIMIT.—The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) ANNUAL LIMIT.—The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) MEDICAL OR SURGICAL BENEFITS.—The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) MENTAL HEALTH BENEFITS.—The term "mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) SUBSTANCE USE DISORDER BENEFITS.—The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

SEC. 2727. [300gg–27] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.[12]

The provisions of section 713 of the Employee Retirement Income Security Act of 1974 shall apply to group health plans, and and[13] health insurance issuers offering group or individual health insurance coverage, as if included in this subpart.

SEC. 2728. [300gg–28] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE.

(a) MEDICALLY NECESSARY LEAVE OF ABSENCE.—In this section, the term "medically necessary leave of absence" means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that—

(1) commences while such child is suffering from a serious illness or injury;

(2) is medically necessary; and

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[12] Section 2706 (prior to its redesignation as 2727 by Public Law 111–148) was added by subsection (a) of section 903 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 (as contained in section 101(f) of division A of Public Law 105–277; 112 Stat. 2681–438). Subsection (c) of such section 903 concerns effective dates, and paragraph (1) of the subsection provides as follows:

"(1) GROUP PLANS.—

"(A) IN GENERAL.—The amendment made by subsection (a) shall apply to group health plans for plan years beginning on or after the date of enactment of this Act.

"(B) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.".

The Public Law was enacted October 21, 1998.

[13] So in law.

(3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) REQUIREMENT TO CONTINUE COVERAGE.—

(1) IN GENERAL.—In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that offers group or individual health insurance coverage, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

(A) the date that is 1 year after the first day of the medically necessary leave of absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) DEPENDENT CHILD DESCRIBED.—A dependent child described in this paragraph is, with respect to a group health plan or individual health insurance coverage, a beneficiary under the plan who—

(A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and

(B) was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) CERTIFICATION BY PHYSICIAN.—Paragraph (1) shall apply to a group health plan or individual health insurance coverage only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) NOTICE.—A group health plan, and a health insurance issuer that offers group or individual health insurance coverage, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) NO CHANGE IN BENEFITS.—A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) CONTINUED APPLICATION IN CASE OF CHANGED COVERAGE.—If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or individual health insurance coverage, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

SEC. 2729. INFORMATION ON PRESCRIPTION DRUGS.

(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

(b) DEFINITION.—For purposes of this section, the term "out-of-pocket cost", with respect to acquisition of a drug, means the amount to be paid by the enrollee under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.

Subpart 2—Exclusion of Plans; Enforcement; Preemption [14]

SEC. 2722. [15] [300gg–21] EXCLUSION OF CERTAIN PLANS.

(a) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—

[14] There is a subpart II (roman II) beginning with section 2711.

[15] The numerical sequence of section enumerators beginning in subpart 2 so in law. See section enumerators at the end of subpart 1 of this part and amendments redesignating section enumerators in subpart 2 by section 1001(4) and section 1563(c)(12) of Public Law 111–148. See footnote accompanying section 2725 regarding ambiguity in placement of sections 2725–2728.

There are conflicting amendments made to provisions of this section by section 1563(a) and section 1563(c)(12)(B) (relating to conforming amendments—originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148). The amendments reflected here are from section 1563(a) of such Public Law and thereby renders the global amendment made by subsection (c)(12)(B) unexecutable.

(1) IN GENERAL.—The requirements of subparts 1 and 2 [16] and part D shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2 [16] otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) PERIOD OF ELECTION.—An election under subparagraph (A) shall apply—

(i) for a single specified plan year, or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) NOTICE TO ENROLLEES.—Under such an election, the plan shall provide for—

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).

(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c), and (d) of section 2702 and the provisions of sections 2701 and 2702(b) to the extent that such provisions apply to genetic information.

(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subparts I and II.

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of subparts 1 and 2 [17] and part D shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

[16] The references to "subparts 1 and 2" probably should read "subparts I and II".
[17] The references to "subparts 1 and 2" probably should read "subparts I and II".

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 [17] and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 [17] and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer [18].

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part and part D shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 27971(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) TREATMENT OF PARTNERSHIPS.—For purposes of this part and part D—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

[18] Section 1563 (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148 provides for an amendment to insert "or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer". Such amendment did not specify where to insert this new language, however, it was carried out by inserting this new language before the period at the end in order to reflect the probable intent of Congress.

(2) EMPLOYER.—In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term "participant" also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SEC. 2723. [300gg–22] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2723, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part and part D with respect to such issuers.

(2) FAILURE TO IMPLEMENT PROVISIONS.—In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part or part D with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) LIMITATION.—The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part or part D only—

(A) as provided under subsection (a)(2); and

(B) with respect to individual health insurance coverage or group health plans that are non-Federal governmental plans.

(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1)—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part or part D applicable to such plan or issuer is subject to a civil money penalty under this subsection.

(B) LIABILITY FOR PENALTY.—In the case of a failure by—

(i) a health insurance issuer, the issuer is liable for such penalty, or

(ii) a group health plan that is a non-Federal governmental plan which is—

(I) sponsored by 2 or more employers, the plan is liable for such penalty, or

(II) not so sponsored, the employer is liable for such penalty.

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and part D and the gravity of the violation.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be

subject to review only as provided under subparagraph (E).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of the district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(3) ENFORCEMENT AUTHORITY RELATING TO GENETIC DISCRIMINATION.—

(A) GENERAL RULE.—In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 2702 or section 2701 or 2702(b)(1) with respect to genetic information in connection with the plan.

(B) AMOUNT.—

(i) IN GENERAL.—The amount of the penalty imposed under this paragraph shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) IN GENERAL.—In the case of 1 or more failures with respect to an individual—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such individual shall not be less than $2,500.

(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) LIMITATIONS.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

SEC. 2724. [300gg–23] PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part, part D, and part C insofar as it relates to this part or part D shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part or part D.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part or part D shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i)[19] substitutes for the reference to "6-month period" in section 2701(a)(1) a reference to any shorter period of time;

(ii)[19] substitutes for the reference to "12 months" and "18 months" in section 2701(a)(2) a reference to any shorter period of time;

[19] Clauses (i) through (vii) probably should be redesignated as subparagraphs (A) through (G). See section 102(a) of Public Law 104–191 (110 Stat. 1971).

(iii)[19] substitutes for the references to "63" days in sections 2701(c)(2)(A) and 2701(d)(4)(A) a reference to any greater number of days;

(iv)[19] substitutes for the reference to "30-day period" in sections 2701(b)(2) and 2701(d)(1) a reference to any greater period;

(v)[19] prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) or expands the exceptions described in such section;

(vi)[19] requires special enrollment periods in addition to those required under section 2701(f); or

(vii)[19] reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B).

(c) RULES OF CONSTRUCTION.—Nothing in this part (other than section 2704) or part D shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) DEFINITIONS.—For purposes of this section—

(1) STATE LAW.—The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term "State" includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.[20]

PART B—INDIVIDUAL MARKET RULES[21]

Subpart 1—Portability, Access, and Renewability Requirements

SEC. 2741. [300gg–41] GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GUARANTEED AVAILABILITY.—

(1) IN GENERAL.—Subject to the succeeding subsections of this section and section 2744, each health insurance issuer that offers health insurance coverage (as defined in section 2791(b)(1)) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

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[20] See footnote accompanying section 2725 regarding ambiguity in placement of sections 2725–2728.

[21] Section 111(b) of Public Law 104–191 (110 Stat. 1987) provides as follows:

"(b) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as provided in this subsection, part B of title XXVII of the Public Health Service Act (as inserted by subsection (a)) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

"(2) APPLICATION OF CERTIFICATION RULES.—The provisions of section 102(d)(2) of this Act shall apply to section 2743 of the the Public Health Service Act in the same manner as it applies to section 2701(e) of such Act.".

With respect to paragraph (2) of such section 111(b), subsection (d) of section 102 of Public Law 104–191 is not divided into paragraphs (1) and (2) (and the subsection relates to a technical correction). Subsection (c)(2) of such section 102 does relate to certifications.

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

(2) SUBSTITUTION BY STATE OF ACCEPTABLE ALTERNATIVE MECHANISM.—The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 2744.

(b) ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term "eligible individual" means an individual—

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c)) is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act, or (C) a State plan under title XIX of such Act (or any successor program), and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b) (relating to nonpayment of premiums or fraud);

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) ALTERNATIVE COVERAGE PERMITTED WHERE NO STATE MECHANISM.—

(1) IN GENERAL.—In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 2744, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) CHOICE OF MOST POPULAR POLICY FORMS.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium

volume of all such policy forms offered by the issuer in the State or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

(3) CHOICE OF 2 POLICY FORMS WITH REPRESENTATIVE COVERAGE.—

(A) IN GENERAL.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section 2744(c)(3)(A) (relating to risk adjustment, risk spreading, or financial subsidization).

(B) LOWER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

(C) HIGHER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if—

(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

(D) WEIGHTED AVERAGE.—For purposes of this paragraph, the weighted average described in this subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in the State in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

(4) ELECTION.—The issuer elections under this subsection shall apply uniformly to all eligible individuals in the State for that issuer. Such an election shall be effective for policies offered during a period of not shorter than 2 years.

(5) ASSUMPTIONS.—For purposes of paragraph (3), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) SPECIAL RULES FOR NETWORK PLANS.—

(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may—

(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and

(ii) it is applying this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(e) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all individuals in the individual market in the State consistent with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer upon denying individual health insurance coverage in any service area in accordance with paragraph (1) may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated, if required under applicable State law, to the applicable State authority that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. A State may provide for the application of this paragraph on a service-area-specific basis.

(e)[22] MARKET REQUIREMENTS.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

[22] So in law. Probably should redesignate the second subsection (e) and subsection (f) as subsections (f) and (g), respectively. See section 111(a) of Pub. L. 104–191 (110 Stat. 1978).

(2) CONVERSION POLICIES.—A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

(f)[22] CONSTRUCTION.—Nothing in this section shall be construed—

(1) to restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable State law; or

(2) to prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

SEC. 2742. [300gg–42] GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) TERMINATION OF PLAN.—The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) and applicable State law.

(4) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if—

(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

(i) the issuer provides notice to the applicable State authority and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

SEC. 2743. [300gg–43] CERTIFICATION OF COVERAGE.

The provisions of section 2701(e) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

SEC. 2744. [300gg–44] STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) WAIVER OF REQUIREMENTS WHERE IMPLEMENTATION OF ACCEPTABLE ALTERNATIVE MECHANISM.—

(1) IN GENERAL.—The requirements of section 2741 shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found to be implementing, in accordance with this section and consistent with section 2762(b), an alternative mechanism (in this section referred to as an "acceptable alternative mechanism")—

(A) under which all eligible individuals are provided a choice of health insurance coverage;

(B) under which such coverage does not impose any preexisting condition exclusion with respect to such coverage;

(C) under which such choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market in such State or that is comparable to a standard option of coverage available under the group or individual health insurance laws of such State; and

(D) in a State which is implementing—

(i) a model act described in subsection (c)(1),

(ii) a qualified high risk pool described in subsection (c)(2), or

(iii) a mechanism described in subsection (c)(3).

(2) PERMISSIBLE FORMS OF MECHANISMS.—A private or public individual health insurance mechanism (such as a health insurance coverage pool or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of such mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State in accordance with this section may constitute an acceptable alternative mechanism.

(b) APPLICATION OF ACCEPTABLE ALTERNATIVE MECHANISMS.—

(1) PRESUMPTION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State is presumed to be implementing an acceptable alternative mechanism in accordance with this section as of July 1, 1997, if, by not later than April 1, 1997, the chief executive officer of a State—

(i) notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 1998, or July 1, 1998, in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation of a mechanism

reasonably designed to be an acceptable alternative mechanism as of January 1, 1998, (or, in the case of a State described in subparagraph (B)(ii), July 1, 1998); and

(ii) provides the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(B) DELAY PERMITTED FOR CERTAIN STATES.—

(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of July 1, 1998; and

(II) must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act.

(C) CONTINUED APPLICATION.—In order for a mechanism to continue to be presumed to be an acceptable alternative mechanism, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

(2) NOTICE.—If the Secretary finds, after review of information provided under paragraph (1) and in consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism is not an acceptable alternative mechanism or is not (or no longer) being implemented, the Secretary—

(A) shall notify the State of—

(i) such preliminary determination, and

(ii) the consequences under paragraph (3) of a failure to implement such a mechanism; and

(B) shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism.

(3) FINAL DETERMINATION.—If, after providing notice and opportunity under paragraph (2), the Secretary finds that the mechanism is not an acceptable alternative mechanism or the State is not implementing such a mechanism, the Secretary shall notify the State that the State is no longer considered to be implementing an acceptable alternative mechanism and

that the requirements of section 2741 shall apply to health insurance coverage offered in the individual market in the State, effective as of a date specified in the notice.

(4) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.

(5) FUTURE ADOPTION OF MECHANISMS.—If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

(c) PROVISION RELATED TO RISK.—

(1) ADOPTION OF NAIC MODELS.—The model act referred to in subsection (a)(1)(D)(i) is the Small Employer and Individual Health Insurance Availability Model Act (adopted by the National Association of Insurance Commissioners on June 3, 1996) insofar as it applies to individual health insurance coverage or the Individual Health Insurance Portability Model Act (also adopted by such Association on such date).

(2) QUALIFIED HIGH RISK POOL.—For purposes of subsection (a)(1)(D)(ii), a "qualified high risk pool" described in this paragraph is a high risk pool that—

(A) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, and

(B) provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of the date of the enactment of this title).

(3) OTHER MECHANISMS.—For purposes of subsection (a)(1)(D)(iii), a mechanism described in this paragraph—

(A) provides for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers; or

(B) is a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

SEC. 2745. [300gg–45] RELIEF FOR HIGH RISK POOLS.

(a) SEED GRANTS TO STATES.—The Secretary shall provide from the funds appropriated under subsection (d)(1)(A) a grant of up to $1,000,000 to each State that has not created a qualified high risk pool as of the date of enactment of the State High Risk Pool Fund-

ing Extension Act of 2006 for the State's costs of creation and initial operation of such a pool.

(b) GRANTS FOR OPERATIONAL LOSSES.—

(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool that—

(A) restricts premiums charged under the pool to no more than 200 percent of the premium for applicable standard risk rates;

(B) offers a choice of two or more coverage options through the pool; and

(C) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State in connection with operation of the pool after the end of the last fiscal year for which a grant is provided under this paragraph;

the Secretary shall provide, from the funds appropriated under paragraphs (1)(B)(i) and (2)(A) of subsection (d) and allotted to the State under paragraph (2), a grant for the losses incurred by the State in connection with the operation of the pool.

(2) ALLOTMENT.—Subject to paragraph (4), the amounts appropriated under paragraphs (1)(B)(i) and (2)(A) of subsection (d) for a fiscal year shall be allotted and made available to the States (or the entities that operate the high risk pool under applicable State law) that qualify for a grant under paragraph (1) as follows:

(A) An amount equal to 40 percent of such appropriated amount for the fiscal year shall be allotted in equal amounts to each qualifying State that is one of the 50 States or the District of Columbia and that applies for a grant under this subsection.

(B) An amount equal to 30 percent of such appropriated amount for the fiscal year shall be allotted among qualifying States that apply for such a grant so that the amount allotted to such a State bears the same ratio to such appropriated amount as the number of uninsured individuals in the State bears to the total number of uninsured individuals (as determined by the Secretary) in all qualifying States that so apply.

(C) An amount equal to 30 percent of such appropriated amount for the fiscal year shall be allotted among qualifying States that apply for such a grant so that the amount allotted to a State bears the same ratio to such appropriated amount as the number of individuals enrolled in health care coverage through the qualified high risk pool of the State bears to the total number of individuals so enrolled through qualified high risk pools (as determined by the Secretary) in all qualifying States that so apply.

(3) SPECIAL RULE FOR POOLS CHARGING HIGHER PREMIUMS.—In the case of a qualified high risk pool of a State which charges premiums that exceed 150 percent of the premium for applicable standard risks, the State shall use at least 50 percent of the amount of the grant provided to the State to carry out this subsection to reduce premiums for enrollees.

(4) LIMITATION FOR TERRITORIES.—In no case shall the aggregate amount allotted and made available under paragraph (2) for a fiscal year to States that are not the 50 States or the District of Columbia exceed $1,000,000.

(c) BONUS GRANTS FOR SUPPLEMENTAL CONSUMER BENEFITS.—

(1) IN GENERAL.—In the case of a State that is one of the 50 States or the District of Columbia, that has established a qualified high risk pool, and that is receiving a grant under subsection (b)(1), the Secretary shall provide, from the funds appropriated under paragraphs (1)(B)(ii) and (2)(B) of subsection (d) and allotted to the State under paragraph (3), a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk pools.

(2) BENEFITS.—A State shall use amounts received under a grant under this subsection to provide one or more of the following benefits:

(A) Low-income premium subsidies.

(B) A reduction in premium trends, actual premiums, or other cost-sharing requirements.

(C) An expansion or broadening of the pool of individuals eligible for coverage, such as through eliminating waiting lists, increasing enrollment caps, or providing flexibility in enrollment rules.

(D) Less stringent rules, or additional waiver authority, with respect to coverage of pre-existing conditions.

(E) Increased benefits.

(F) The establishment of disease management programs.

(3) ALLOTMENT; LIMITATION.—The Secretary shall allot funds appropriated under paragraphs (1)(B)(ii) and (2)(B) of subsection (d) among States qualifying for a grant under paragraph (1) in a manner specified by the Secretary, but in no case shall the amount so allotted to a State for a fiscal year exceed 10 percent of the funds so appropriated for the fiscal year.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit a State that, on the date of the enactment of the State High Risk Pool Funding Extension Act of 2006, is in the process of implementing a program to provide benefits of the type described in paragraph (2), from being eligible for a grant under this subsection.

(d) FUNDING.—

(1) APPROPRIATION FOR FISCAL YEAR 2006.—There are authorized to be appropriated for fiscal year 2006—

(A) $15,000,000 to carry out subsection (a); and

(B) $75,000,000, of which, subject to paragraph (4)—

(i) two-thirds of the amount appropriated shall be made available for allotments under subsection (b)(2); and

(ii) one-third of the amount appropriated shall be made available for allotments under subsection (c)(3).

(2) AUTHORIZATION OF APPROPRIATIONS FOR FISCAL YEARS 2007 THROUGH 2010.—There are authorized to be appropriated

$75,000,000 for each of fiscal years 2007 through 2010, of which, subject to paragraph (4)—

(A) two-thirds of the amount appropriated for a fiscal year shall be made available for allotments under subsection (b)(2); and

(B) one-third of the amount appropriated for a fiscal year shall be made available for allotments under subsection (c)(3).

(3) AVAILABILITY.—Funds appropriated for purposes of carrying out this section for a fiscal year shall remain available for obligation through the end of the following fiscal year.

(4) REALLOTMENT.—If, on June 30 of each fiscal year for which funds are appropriated under paragraph (1)(B) or (2), the Secretary determines that all the amounts so appropriated are not allotted or otherwise made available to States, such remaining amounts shall be allotted and made available under subsection (b) among States receiving grants under subsection (b) for the fiscal year based upon the allotment formula specified in such subsection.

(5) NO ENTITLEMENT.—Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

(e) APPLICATIONS.—To be eligible for a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(f) ANNUAL REPORT.—The Secretary shall submit to Congress an annual report on grants provided under this section. Each such report shall include information on the distribution of such grants among States and the use of grant funds by States.

(g) DEFINITIONS.—In this section:

(1) QUALIFIED HIGH RISK POOL.—

(A) IN GENERAL.—The term "qualified high risk pool" has the meaning given such term in section 2744(c)(2), except that a State may elect to meet the requirement of subparagraph (A) of such section (insofar as it requires the provision of coverage to all eligible individuals) through providing for the enrollment of eligible individuals through an acceptable alternative mechanism (as defined for purposes of section 2744) that includes a high risk pool as a component.

(2) STANDARD RISK RATE.—The term "standard risk rate" means a rate—

(A) determined under the State high risk pool by considering the premium rates charged by other health insurers offering health insurance coverage to individuals in the insurance market served;

(B) that is established using reasonable actuarial techniques; and

(C) that reflects anticipated claims experience and expenses for the coverage involved.

(3) STATE.—The term "State" means any of the 50 States and the District of Columbia and includes Puerto Rico, the Vir-

gin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 2746. [300gg–46] DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage or a health insurance issuer offering short-term limited duration insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

(1) made prior to the individual finalizing plan selection; and

(2) included on any documentation confirming the individual's enrollment.

(c) REPORTING.—A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, the Secretary shall finalize, through notice-and-comment rulemaking, the timing, form, and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.

Subpart 2—Other Requirements

SEC. 2751. [300gg–51] STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

(a) IN GENERAL.—The provisions of section 2704 (other than subsections (d) and (f)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(b) NOTICE REQUIREMENT.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.

(c) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) CONSTRUCTION.—Section 2762(a) shall not be construed as superseding a State law described in paragraph (1).

SEC. 2752. [300gg–52] REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.[23]

The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

SEC. 2753.[24] [300gg–53] PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION.

(a) PROHIBITION ON GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market may not establish rules for the eligibility (including continued eligibility) of any individual to enroll in individual health insurance coverage based on genetic information.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from establishing rules for eligibility for an individual to enroll in individual health insurance coverage based on the manifestation of a disease or disorder in that individual, or in a family member of such indi-

[23] Section 2752 was added by subsection (b) of section 903 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 (as contained in section 101(f) of division A of Public Law 105–277 (112 Stat. 2681–438)). Subsection (c) of such section 903 concerns effective dates, and paragraph (2) of the subsection provides as follows:

"(2) INDIVIDUAL PLANS.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.".

The Public Law was enacted October 21, 1998.

[24] Another section designated as section 2753 appears at the end of part B. There are details in a footnote regarding its placement at the end.

vidual where such family member is covered under the policy that covers such individual.

(b) PROHIBITION ON GENETIC INFORMATION IN SETTING PREMIUM RATES.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from adjusting premium or contribution amounts for an individual on the basis of a manifestation of a disease or disorder in that individual, or in a family member of such individual where such family member is covered under the policy that covers such individual. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other individuals covered under the policy issued to such individual and to further increase premiums or contribution amounts.

(c) PROHIBITION ON GENETIC INFORMATION AS PREEXISTING CONDITION.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market may not, on the basis of genetic information, impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or in paragraphs (1) and (2) of subsection (e) shall be construed to preclude a health insurance issuer from imposing any preexisting condition exclusion for an individual with respect to health insurance coverage on the basis of a manifestation of a disease or disorder in that individual.

(d) GENETIC TESTING.—

(1) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A health insurance issuer offering health insurance coverage in the individual market shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) RULE OF CONSTRUCTION REGARDING PAYMENT.—

(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to preclude a health insurance issuer offering health insurance coverage in the individual market from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be re-

vised from time to time) consistent with subsection (a) and (c).

(B) LIMITATION.—For purposes of subparagraph (A), a health insurance issuer offering health insurance coverage in the individual market may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) RESEARCH EXCEPTION.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(e) PROHIBITION ON COLLECTION OF GENETIC INFORMATION.—

(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual market shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 2791).

(2) PROHIBITION ON COLLECTION OF GENETIC INFORMATION PRIOR TO ENROLLMENT.—A health insurance issuer offering health insurance coverage in the individual market shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan in connection with such enrollment.

(3) INCIDENTAL COLLECTION.—If a health insurance issuer offering health insurance coverage in the individual market obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(f) GENETIC INFORMATION OF A FETUS OR EMBRYO.—Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

Subpart 3—General Provisions [25]

SEC. 2761. [300gg–61] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Subject to section 2762, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual market meet the requirements established under this part with respect to such issuers.

(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to health insurance issuers in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in the individual market in such State.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to enforcement of the provisions of this part with respect to issuers of health insurance coverage in the individual market in a State as the Secretary has under section 2722(b)(2), and section 2722(b)(3) with respect to violations of genetic nondiscrimination provisions, in relation to the enforcement of the provisions of part A with respect to issuers of health insurance coverage in the small group market in the State.

SEC. 2762. [300gg–62] PREEMPTION. [26]

(a) IN GENERAL.—Subject to subsection (b), nothing in this part (or part C insofar as it applies to this part) shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.

(b) RULES OF CONSTRUCTION.—(1) Nothing in this part (or part C insofar as it applies to this part) shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

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[25] Section 605(a)(3) of Public Law 104–204 (110 Stat. 2941) adds this subpart designation and heading to part B.

[26] Section 1563(c)(15)(A) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148 provides for an amendment in the section heading by inserting "AND APPLICATION" before the period. Section 1563(c)(15)(B) (as so redesignated) of such Public Law provides for an amendment to add at the end a new subsection (c). See note set out in italic typeface that appears after subsection (b) below.

The amendments to section 2762 made by section 1563(c)(15), as so redesignated, takes effect on date of enactment of Public Law 111–148 (March 23, 2010); however, they're being treated here as if they take effect on January 1, 2014 to reflect the probable intent of Congress and in order to be consistent with the execution of different amendments made by such section 1563 to part A of this title (see details regarding the effective date in a note to a second version of part A).

(2) Nothing in this part (other than section 2751) shall be construed as requiring health insurance coverage offered in the individual market to provide specific benefits under the terms of such coverage.

(c) APPLICATION OF PART A PROVISIONS.— [27]

(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.

SEC. 2763. [300gg–63] GENERAL EXCEPTIONS.

(a) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(1).

(b) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate, or contract of insurance.

SEC. 2753. [300gg–54] COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE. [28]

The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. [300gg–91] DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimburse-

[27] Section 1563(c)(15)(B) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148 provides for an amendment to add a new subsection (c) at the end of section 2762. Such amendment takes effect on date of enactment of Public Law 111–148 (March 23, 2010); however, they're being treated here as if they take effect on January 1, 2014 to reflect the probable intent of Congress and in order to be consistent with the execution of different amendments made by such section 1563 to part A of this title (see details regarding the effective date in a note to a second version of part A).

[28] The placement of section 2753 at the end of subpart 3 is so in law. See amendment made by section 2(b)(2) of Public Law 110–381 122 Stat. 4084). Section 102(b)(1)(A) of Public Law 110–233 redesignated subpart 3 of part B as subpart 2. Also, another section designated as section 2753 was added by section 102(b)(1)(B) of such Public Law (122 Stat. 893).

ment, or otherwise. Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance

coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d)[29] OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

[29] For version of law for section 2791(d)(20)–(21) (as amended by section 1563(b) (relating to conforming amendments--originally designated as section 1562 and redesignated as section 1563 by section 10107(b)(1)) of Public Law 111–148) see note set out in italic typeface that appears after paragraph (19).

(3) BONA FIDE ASSOCIATION.—The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term "church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term "governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term "Federal governmental plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term "non-Federal governmental plan" means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term "participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(17) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(19) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(20) QUALIFIED HEALTH PLAN.—The term "qualified health plan" has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) EXCHANGE.—The term "Exchange" means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

(1) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the pre-

ceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) STATE OPTION TO EXTEND DEFINITION OF SMALL EMPLOYER.—Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

SEC. 2792. [300gg–92] REGULATIONS.

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this title.

SEC. 2793. [300gg–93] HEALTH INSURANCE CONSUMER INFORMATION.

(a) IN GENERAL.—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

(2) health insurance ombudsman programs.

(b) ELIGIBILITY.—

(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

(e) FUNDING.—

(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

SEC. 2794. [300gg–94] ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

(a) INITIAL PREMIUM REVIEW PROCESS.—

(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, begin-

ning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

(b) CONTINUING PREMIUM REVIEW PROCESS.—

(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) GRANTS IN SUPPORT OF PROCESS.—

(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage;

(B) in providing information and recommendations to the Secretary under subsection (b)(1); and

(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.

(2) FUNDING.—

(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.

(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under sub-

section (c)(1)(C) to compel health insurance issuers to provide data to the center.

SEC. 2794. [300gg–95] UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.[30]

The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.

PART D—ADDITIONAL COVERAGE PROVISIONS

SEC. 2799A–1. [300gg–111] PREVENTING SURPRISE MEDICAL BILLS.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

[30] So in law. There are two sections 2794s'. Sections 1003 and 6603 of Public Law 111–148 add new section 2794s' to the end of part C of title XXVII.

(iv) the group health plan or health insurance issuer, respectively—

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—

(A) AUDIT PROCESS.—

(i) IN GENERAL.—Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that—

(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health in-

surance issuer described in clause (ii) of such paragraph (3)(E).

(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage; and

(II) may audit any group health plan or health insurance issuer offering group or individual health insurance coverage if the Secretary has received any complaint or other information about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—

(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by individual market, large group market, and small group market;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering group or individual health insurance coverage.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining pay-

ment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) DEFINITIONS.—In this part and part E:

(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term "emergency department of a hospital" includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

(B) EMERGENCY MEDICAL CONDITION.—The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) EMERGENCY SERVICES.—

(i) IN GENERAL.—The term "emergency services", with respect to an emergency medical condition, means—

(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) INCLUSION OF ADDITIONAL SERVICES.—

(I) IN GENERAL.—For purposes of this subsection and section 2799B–1, in the case of a participant, beneficiary, or enrollee who is enrolled in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished services described in

clause (i) with respect to an emergency medical condition, the term "emergency services" shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

(aa) Such provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799B–2(d) with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

(dd) Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term "independent freestanding emergency department" means a health care facility that—

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

(E) QUALIFYING PAYMENT AMOUNT.—

(i) IN GENERAL.—The term "qualifying payment amount" means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) NEW PLANS AND COVERAGE.—The term "qualifying payment amount" means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(I) for the first year in which such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan or coverage and furnished during such first year; and

(II) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively,

is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term "qualifying payment amount"—

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to "furnished during 2022" shall be treated as a

reference to furnished during such first sufficient information year, the reference to "in 2019" shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to "furnished during 2023 or a subsequent year" shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) INSURANCE MARKET.—For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

(I) The individual market.

(II) The large group market (other than plans described in subclause (IV)).

(III) The small group market (other than plans described in subclause (IV)).

(IV) In the case of a self-insured group health plan, other self-insured group health plans.

(v) DEFINITIONS.—For purposes of this subparagraph:

(I) FIRST COVERAGE YEAR.—The term "first coverage year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) FIRST SUFFICIENT INFORMATION YEAR.—The term "first sufficient information year" means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for

which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) NEWLY COVERED ITEM OR SERVICE.—The term "newly covered item or service" means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

(i) NONPARTICIPATING EMERGENCY FACILITY.—The term "nonparticipating emergency facility" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) PARTICIPATING EMERGENCY FACILITY.—The term "participating emergency facility" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

(i) NONPARTICIPATING PROVIDER.—The term "nonparticipating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) PARTICIPATING PROVIDER.—The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State

law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) RECOGNIZED AMOUNT.—The term "recognized amount" means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(I) SPECIFIED STATE LAW.—The term "specified State law" means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(J) STABILIZE.—The term "to stabilize", with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(K) OUT-OF-NETWORK RATE.—The term "out-of-network rate" means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance

issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I),subsection (b)(1)(C), or section 2799A–2(a)(3)(A), as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified IDR entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(L) COST-SHARING.—The term "cost-sharing" includes copayments, coinsurance, and deductibles.

(b) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799B–2(d)) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and

services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

(C) not later than 30 calendar days after the bill for such services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable,with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) DEFINITIONS.—In this section:

(A) PARTICIPATING HEALTH CARE FACILITY.—

(i) IN GENERAL.—The term "participating health care facility" means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or group or individual health insurance coverage, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act).

(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act.

(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) VISIT.—The term "visit" shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(c) DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS.—

(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dis-

pute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the "IDR process") under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a "qualified IDR item or service"), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect to such item or service pursuant to subsection (b) of such section.

(3) TREATMENT OF BATCHING OF ITEMS AND SERVICES.—

(A) IN GENERAL.—Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including mini-

mizing costs) of the IDR process. Such items and services may be so considered only if—

(i) such items and services to be included in such determination are furnished by the same provider or facility;

(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) TREATMENT OF BUNDLED PAYMENTS.—In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) CERTIFICATION AND SELECTION OF IDR ENTITIES.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified—

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not—

(I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) PERIOD OF CERTIFICATION.—Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) REVOCATION.—A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) PETITION FOR DENIAL OR WITHDRAWAL.—The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group or individual health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) SELECTION OF CERTIFIED IDR ENTITY.—The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method—

(i) that allows for the group health plan or health insurance issuer offering group or individual health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that—

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation—

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); and

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the "certified IDR entity" with respect to such determination.

(5) PAYMENT DETERMINATION.—

(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

(i) shall each submit to the certified IDR entity with respect to such determination—

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) CONSIDERATIONS IN DETERMINATION.—

(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined

by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) PROHIBITION ON CONSIDERATION OF CERTAIN FACTORS.—In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799B–1 or 2799B–2 (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United

States Code, or under chapter 17 of title 38, United States Code.

(E) EFFECTS OF DETERMINATION.—

(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A)—

(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

(ii) SUSPENSION OF CERTAIN SUBSEQUENT IDR REQUESTS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) SUBSEQUENT SUBMISSION OF REQUESTS PERMITTED.—In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) REPORTS.—The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period de-

scribed in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage and submitted to a certified IDR entity—

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) TIMING OF PAYMENT.—The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

(A) PUBLICATION OF INFORMATION.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services—

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) INFORMATION.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage—

(i) a description of each item and service included with respect to such notification;

(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) ADMINISTRATIVE FEE.—

(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for

participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(d) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

(1) Any deductible applicable to such plan or coverage.

(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage

(f) ADVANCED EXPLANATION OF BENEFITS.—

(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, with respect to a notification submitted under section 2799B–6 by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from

the provider or facility (or authorized representative of such participant, beneficiary, or enrollee), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service and—

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities, if any.

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B).

(D) A good faith estimate of the amount of any cost-sharing for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

(E) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

(F) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

(G) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or

requesting) the item or service, to be furnished and is subject to change.

(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

(2) AUTHORITY TO MODIFY TIMING REQUIREMENTS IN THE CASE OF SPECIFIED ITEMS AND SERVICES.—

(A) IN GENERAL.—In the case of a participant, beneficiary, or enrollee scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant, beneficiary, or enrollee with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant, beneficiary, or enrollee has been furnished such item or service.

(B) SPECIFIED ITEM OR SERVICE DEFINED.—For purposes of subparagraph (A), the term "specified item or service" means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.

SEC. 2799A–2. [300gg–112] ENDING SURPRISE AIR AMBULANCE BILLS.

(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan or health insurance issuer, respectively, shall—

(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such

provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 2799A–1(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

(b) DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS.—

(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the "IDR process") under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a "qualified IDR air ambulance services"), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 2799A–1(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect to such item or service pursuant to subsection (b) of such section.

(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 2799A–1(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 2799A–1(c) with respect to items and services described in such section.

(4) IDR ENTITIES.—

(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 2799A–1(c)(4).

(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 2799A–1(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determina-

tion of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 2799A–1(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the "certified IDR entity" with respect to such determination.

(5) PAYMENT DETERMINATION.—

(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall—

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

(i) shall each submit to the certified IDR entity with respect to such determination—

(I) an offer for a payment amount for such services furnished by such provider; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) CONSIDERATIONS IN DETERMINATION.—

(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

(I) the qualifying payment amounts (as defined in section 2799A–1(a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

(iii) PROHIBITION ON CONSIDERATION OF CERTAIN FACTORS.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

(D) EFFECTS OF DETERMINATION.—The provisions of section 2799A–1(c)(5)(E)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as

such provisions apply with respect to a determination of a certified IDR entity under section 2799A–1(c)(5)(E), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 2799A–1(c)(5)(F) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 2799A–1(c), the parties to such notification and a determination made under section 2799A–1(c)(5)(A).

(6) TIMING OF PAYMENT.—The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to an air ambulance service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Health and Human Services—

(i) the number of notifications submitted under the IDR process during such calendar quarter;

(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E)during such calendar quarter.

(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group or individual health insurance coverage—

(i) a description of each air ambulance service included in such notification;

(ii) the geography in which the services included in such notification were provided;

(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) ambulance vehicle type, including the clinical capability level of such vehicle;

(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) ADMINISTRATIVE FEE.—

(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process

under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(c) DEFINITIONS.—For purposes of this section:

(1) AIR AMBULANCE SERVICE.—The term "air ambulance service" means medical transport by helicopter or airplane for patients.

(2) QUALIFYING PAYMENT AMOUNT.—The term "qualifying payment amount" has the meaning given such term in section 2799A–1(a)(3).

(3) NONPARTICIPATING PROVIDER.—The term "nonparticipating provider" has the meaning given such term in section 2799A–1(a)(3).

SEC. 2799A-3. [300gg–113] CONTINUITY OF CARE.

(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

(A) such contractual relationship is terminated (as defined in subsection (b));

(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage; or

(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

(i) the 90-day period beginning on such date; or

(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) DEFINITIONS.—In this section:

(1) CONTINUING CARE PATIENT.—The term "continuing care patient" means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

(2) SERIOUS AND COMPLEX CONDITION.—The term "serious and complex condition" means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that is—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) TERMINATED.—The term "terminated" includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SEC. 2799A–4. [300gg–114] MAINTENANCE OF PRICE COMPARISON TOOL.

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

SEC. 2799A–5. [300gg–115] PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall—

(A) establish the verification process described in paragraph (2);

(B) establish the response protocol described in paragraph (3);

(C) establish the database described in paragraph (4); and

(D) include in any directory (other than the database described in subparagraph (C)) containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9.

(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care pro-

vider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

(B) retains such communication in such individual's file for at least 2 years following such response.

(4) DATABASE.—The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, a database on the public website of such plan or issuer that contains—

(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

(B) provider directory information with respect to each such provider and facility.

(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

(6) DEFINITION.—For purposes of this subsection, the term "provider directory information" includes, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

(b) COST-SHARING FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of

the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service, the plan or coverage—

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 2799A–1 applies—

(1) information in plain language on—

(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contrac-

tual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

(C) the requirements applied under section 2799A-1; and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

[There is no section 2799A–6 in law.]

SEC. 2799A–7. [300gg–117] OTHER PATIENT PROTECTIONS.

(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) ACCESS TO PEDIATRIC CARE.—

(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(c) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) GENERAL RIGHTS.—

(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or health insurance coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 2799A–8. [300gg–118] AIR AMBULANCE REPORT REQUIREMENTS.

(a) IN GENERAL.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury—

(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

(2) not later than the date that is 90 days after the last day of the calendar year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, is each of the following:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-spon-

sored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

(C) Whether the transport in which the services were furnished originated in a rural or urban area.

(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

(2) Such other information regarding providers of air ambulance services as the Secretary may specify.

SEC. 2799A–9. [300gg–119] INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND GROUP AND INDIVIDUAL MARKET CONSUMERS.—

(1) GROUP HEALTH PLANS.—A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(3) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).

(4) ATTESTATION.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

(5) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

SEC. 2799A–10. [300gg–120] REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year thereafter, a group health plan or health insurance issuer offering group or individual health insurance coverage (except for a church plan) shall submit to the Secretary, the Secretary of Labor, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

(1) The beginning and end dates of the plan year.

(2) The number of enrollees.

(3) Each State in which the plan or coverage is offered.

(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.

(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

(A) the type of costs, including—

(i) hospital costs;

(ii) health care provider and clinical service costs, for primary care and specialty care separately;

(iii) costs for prescription drugs; and

(iv) other medical costs, including wellness services; and

(B) spending on prescription drugs by—

(i) the health plan or coverage; and

(ii) the enrollees.

(8) The average monthly premium—

(A) paid by employers on behalf of enrollees, as applicable; and

(B) paid by enrollees.

(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, with respect to prescription drugs prescribed to enrollees in the plan or coverage, including—

(A) the amounts so paid for each therapeutic class of drugs; and

(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting through the Assistant Secretary of Planning and Evaluation and in coordination with the Inspector General of the Department of Health and Human Services, shall make available on the internet website of the Department of Health and Human Services a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).

PART E—HEALTH CARE PROVIDER REQUIREMENTS

SEC. 2799B–1. [300gg–131] BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the participant, beneficiary, or enrollee for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for such services (as determined in accordance with clauses (ii) and (iii) of section 2799A–1(a)(1)(C), of section 9816(a)(1)(C) of the Internal Revenue Code of 1986, and of section 716(a)(1)(C) of the Employee Retirement Income Security Act of 1974, as applicable); and

(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing requirement for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2799A–1(a)(1)(C), of section 9816(a)(1)(C) of the Internal Revenue Code of 1986, and of section 716(a)(1)(C) of the Employee Retirement Income Security Act of 1974, as applicable).

(b) DEFINITION.—In this section, the term "visit" shall have such meaning as applied to such term for purposes of section 2799A–1(b).

SEC. 2799B–2. [300gg–132] BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

(a) IN GENERAL.—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, items or services

(other than emergency services to which section 2799B–1 applies) for which benefits are provided under the plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing requirement for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 2799A–1(b)(1) of section 9816(b)(1) of the Internal Revenue Code of 1986, and of section 716(b)(1) of the Employee Retirement Income Security Act of 1974, as applicable).

(b) EXCEPTION.—

(1) IN GENERAL.—Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (d).

(2) ANCILLARY SERVICES DESCRIBED.—For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(3) EXCEPTION.—The Secretary may, through rulemaking, establish a list (and update such list periodically) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

(c) CLARIFICATION.—In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a "covered item or service"), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

(d) NOTICE AND CONSENT TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—

(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of

this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

(A) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 72 hours prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior to the date on which the individual is furnished such items or services (or, in the case that the participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant, beneficiary, or enrollee, (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

(i) contains the information required under paragraph (2);

(ii) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and

(iii) is available in the 15 most common languages in the geographic region of the applicable facility;

(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility; and

(C) provides a signed copy of such consent to the participant, beneficiary, or enrollee through mail or email (as selected by the participant, beneficiary, or enrollee).

(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(i), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health in-

surance coverage offered by a health insurance issuer, is each of the following:

(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

(3) CONSENT DESCRIBED TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary, in consultation with the Secretary of Labor, through guidance that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that —

(A) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—

(i) provided with the written notice under paragraph (1)(A);

(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

(iii) provided the opportunity to receive the written notice under paragraph (1)(A) in the form selected by the participant, beneficiary or enrollee; and

(B) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (1)(A) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility.

(4) RULE OF CONSTRUCTION.—The consent described in paragraph (3), with respect to a participant, beneficiary, or en-

rollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(B), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 7-year period after the date on which such item or service is so furnished.

(f) DEFINITIONS.—In this section:

(1) The terms "nonparticipating provider" and "participating provider" have the meanings given such terms, respectively, in subsection (a)(3) of section 2799A–1.

(2) The term "participating health care facility" has the meaning given such term in subsection (b)(2) of section 2799A–1.

(3) The term "nonparticipating facility" means—

(A) with respect to emergency services (as defined in section 2799A–1(a)(3)(C)(i)) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services described in section 2799A–1(a)(3)(C)(ii) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(4) The term "participating facility" means—

(A) with respect to emergency services (as defined in clause (i) of section 2799A–1(a)(3)(C)) that are not described in clause(ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with re-

spect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services that pursuant to clause (ii) of section 2799A–1(a)(3)(C), of section 9816(a)(3) of the Internal Revenue Code of 1986, and of section 716(a)(3) of the Employee Retirement Income Security Act of 1974, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

SEC. 2799B–3. [300gg–133] PROVIDER REQUIREMENTS WITH RESPECT TO DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.

Beginning not later than January 1, 2022, each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer a one-page notice (either postal or electronic mail, as specified by the participant, beneficiary, or enrollee) in clear and understandable language containing information on—

(1) the requirements and prohibitions of such provider or facility under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

(2) any other applicable State law requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

SEC. 2799B–4. [300gg–134] ENFORCEMENT.

(a) STATE ENFORCEMENT.—

(1) STATE AUTHORITY.—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part to satisfy such requirements applicable to the provider or facility.

(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements to which paragraph (1)

applies with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

(3) NOTIFICATION OF APPLICABLE SECRETARY.—A State may notify the Secretary of Labor, Secretary of Health and Human Services, or the Secretary of the Treasury, as applicable, of instances of violations of sections 2799B–1, 2799B–2, or 2799B–5 with respect to participants, beneficiaries, or enrollees under a group health plan or group or individual health insurance coverage, as applicable offered by a health insurance issuer and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) IN GENERAL.—If a provider or facility is found by the Secretary to be in violation of a requirement to which subsection (a)(1) applies, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and provide a response to such complaints within 60 days of receipt of such complaints.

(4) EXCEPTION.—The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, section 2799B–1 or 2799B–2 (or, in the case of a provider of air ambulance services, section 2799B–5) with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent

that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.

SEC. 2799B–5. [300gg–135] AIR AMBULANCE SERVICES.

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished in a plan year beginning on or after January 1, 2022, air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 2799A–2(a), section 717(a) of the Employee Retirement Income Security Act of 1974, or section 9817(a) of the Internal Revenue Code of 1986, as applicable).

SEC. 2799B–6. [300gg–136] PROVISION OF INFORMATION UPON REQUEST AND FOR SCHEDULED APPOINTMENTS.

Each health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to—

(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

SEC. 2799B–7. [300gg–137] PATIENT-PROVIDER DISPUTE RESOLUTION.

(a) IN GENERAL.—Not later than January 1, 2022, the Secretary shall establish a process (in this subsection referred to as

the "patient-provider dispute resolution process") under which an uninsured individual, with respect to an item or service, who received, pursuant to section 2799B–6, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term "uninsured individual" means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

(b) SELECTION OF ENTITIES.—Under the patient-provider dispute resolution process, the Secretary shall, with respect to a determination sought by an individual under subsection (a), with respect to charges to be paid by such individual to a health care provider or health care facility described in such paragraph for an item or service furnished to such individual by such provider or facility, provide for—

(1) a method to select to make such determination an entity certified under subsection (d) that—

(A) is not a party to such determination or an employee or agent of such party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the "selected dispute resolution entity" with respect to such determination.

(c) ADMINISTRATIVE FEE.—The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

(d) CERTIFICATION.—The Secretary shall establish or recognize a process to certify entities under this subparagraph. Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 2799A–1(c).

SEC. 2799B–8. [300gg–138] CONTINUITY OF CARE.

A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided under a group health plan or group or individual health insurance coverage pursuant to section 2799A–3, section 9818 of the Internal Revenue Code of 1986, or section 718 of the Employee Retirement Income Security Act of 1974—

(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 2799A–3, 9818, or 718) for such items and services as payment in full for such items and services; and

(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.

SEC. 2799B–9. [300gg–139] PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PROVIDER BUSINESS PROCESSES.—Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1), section 720(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9820(a)(1) of the Internal Revenue Code of 1986, as applicable; and

(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

(b) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 2799A–5(b), section 720(b) of the Employee Retirement Income Security Act of 1974, or section 9820(b) of the Internal Revenue Code of 1986, as applicable, and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-

network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2799A–5(a), section 720(a) of the Employee Retirement Income Security Act of 1974, or section 9820(a) of the Internal Revenue Code of 1986, as applicable; or

(2) that the plan or issuer bear financial responsibility, including under section 2799A–5(b), section 720(b) of the Employee Retirement Income Security Act of 1974, or section 9820(b) of the Internal Revenue Code of 1986, as applicable, for providing inaccurate network status information to an enrollee.

(d) DEFINITION.—For purposes of this section, the term "provider directory information" includes the names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers, and the names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.